DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Supportive Living
DSL-2468 (Rev. 03/2002)

STATE OF WISCONSIN

APPLICATION FOR SERVICES WITH THE BUREAU FOR THE BLIND

Instructions: Complete and sign this form. Completion of this form is voluntary. Personally identifiable information collected on this form is confidential and will only be used in determining eligibility for services.

Name - Client Last	First	M.I.
Street or P.O. Box		Apt. #
City	Zip Code	County
Telephone Number (Include Area Code)		
Birthdate (mm/dd/yyyy)	Gender ☐ Female ☐ Male	Age of Onset
Race / Ethnicity	Highest Level of Education	
Source of Referral	Marital Status	
Contact Person		
Name	Relationship	
Telephone Number		

What is your visual impairment?

How does your visual impairment impact your ability to complete daily living tasks / activities?

☐ **Yes** ☐ **No** **Have you had an examination or received treatment from a doctor / specialist regarding your visual impairment? If "Yes", indicate doctor, dates and places of exams.**

☐ **Yes** ☐ **No** **Do you have other health concerns / conditions? If "Yes", list them.**

☐ **Yes** ☐ **No** **Do you take any prescription medications? If "Yes", list them.**

X

SIGNATURE - Client / Representative

Date Signed